EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT

DISTRICT OF UTAH, CENTRAL DIVISION

JOSHUA CHATWIN, Plaintiff, vs. DRAPER CITY; OFFICER J. PATTERSON, in his individual and official capacity; OFFICER DAVID HARRIS, in his individual and official capacity; OFFICER HEATHER BAUGH, in her individual and official capacity; and JOHN DOES -10, Defendants.	Deposition of: WALTER REICHERT, M.D. Civil No. 2:14-cv-00375 Judge Dale A. Kimball

June 24, 2016 * 3:47 p.m.

Location: Western Neurological Center, P.C.
1187 East 3900 South
Salt Lake City, Utah 84124

Reporter: Lisa Bernardo, CSR, RPR

A. She outlined that she was -- that she was defending a client, this is, again, my memory, I didn't write anything down, that had been mistreated. I don't remember the exact conversation, okay, this is my memory. That had been mistreated, in her opinion, by the Draper Police Department. I hope I've even got the right police department right. This is it. I guess this is it. And had been at IMC and had suffered a brain injury and had not had any medical follow-up, and that is why she was a little desperate to get somebody to see her client because he had not had any medical follow-up since his admission to Intermountain Medical Center. That's what I remember.

Q. Did she talk about -- what you recall her saying as far as the mistreatment, did she tell you what kind of mistreatment her client suffered?

A. No. No. She told me he had a -- she may have said he had a skull fracture. I don't remember that for sure, but I can remember it was some kind of a head injury. And it was a short conversation. I said, well, let me think about it for a day. Oh, I don't know if I want to do it. And then I called her back and said, okay, I'll do it, you seem a little desperate.

A. Correct.

Q. So that is a direct quote from Ms. Marcy?

A. Correct.

Q. So at that point in time, did she provide you any information about why she believed Mr. Chatwin was thrown to the ground?

A. No.

Q. But she is the one that used that term, "thrown to the ground"?

A. Yes.

Q. And you then go on and offer your opinion. "It is my opinion that Mr. Chatwin suffered injuries after being thrown to the cement. This will result in future damages."

And that's your stated opinion to that question, correct?

A. Correct.

Q. I would like to look specifically at that opinion for a moment. When you use the term "thrown to the cement," what are you basing the fact that he suffered those injuries because he was thrown to the cement?

A. I base that opinion on his injuries. If you're wondering do I know that he was thrown to the ground, of course, I don't know that he was thrown to

the ground because, of course, it's obvious that I wasn't there. But my opinion is based on his injuries, not being thrown. Does that make -- do I make myself clear?

Q. No. I need to get a little more clarification from that. Based upon his injuries alone, would you be able to tell us to a reasonable degree of medical certainty that he actually had been thrown to the ground?

A. I don't think I can state that.

Q. So you're not of the opinion that his physical injuries to a reasonable medical degree of certainty indicate that he actually was physically thrown to the ground?

A. Let me see if I can answer your question this way, Mr. Hamilton. I am not an expert in the physics of bodily harm, can I say, do you know what I mean, or the physics of seeing people twisted and turned. So in that sense, I don't think I can answer your question to know if he was actually thrown or if he fell or exactly what happened. Does that answer your question?

Q. Sure. You don't have any expertise in kinesiology --

A. That would be a good word to use.

Q. -- is that correct?

A. That is correct.

Q. And so you're not some forensic expert that's looking at injuries and trying to determine what caused those injuries, true?

A. I cannot -- I am not an expert in that kind of field.

Q. And so you cannot testify or provide an expert opinion about what type of action caused an injury, true?

A. I really can't. I am just on, look, I -- I'll hit the rewind button for one second. I see the patient. It's been a couple of years now because his accident, if I remember, it was like 2012. '14. Excuse me. Oh, '10. Oh, my God. Okay. That's a long time ago. Excuse me. And I was not there. I am not an expert in the physics of bodies twisting and turning. I know what he suffered, but exactly what kind of force it may have taken to have him suffer those injuries and what exact position he was in and these kind of details, I can only rely on the evidence from what I have here. Does that answer your question?

Q. It does, but I want to make sure the record is clear. So when you state, "It is my

opinion that Mr." -- you put Chaplin --

A. That's a mistype.

Q. A typo?

A. Yeah.

Q. "Mr. Chatwin suffered injuries after being thrown to the cement." That's really not your opinion. You are not saying that he was thrown to the cement?

A. There's two answers in that question. One, he suffered injuries, and, two, was he thrown. I guess I would have to say if we're deciding. If we're going to parse that sentence up, I would have to say that he did suffer injuries and how those injuries occurred after being -- was he thrown or did they occur in some other way, I can't answer.

Q. Okay. So your opinion really is that he did suffer injuries?

A. That is true.

Q. Going to the next sentence, you say, "This will result in future damages."

Now, with respect to that sentence, is that your opinion?

A. It is.

Q. What type of future damages do you entail that he may suffer?

A. Yes.
Q. The injury he suffered?
A. The injury he suffered.
Q. Going to (b), "Left cranial nerve VIII damage producing left sensorineural hearing loss, and subjective decreased hearing and tinnitus. This opinion is based on his audiometric examination showing decreased high frequency hearing on the left, his symptoms and his physical examination."
A. (Nodding head in the affirmative.)
Q. So, sir, let's get back to your qualification. You're a neurologist, correct?
A. I'm a neurologist, yes.
Q. You are not an ear, nose, throat doctor --
A. I am not.
Q. -- for the layperson's term?
You're not an audio?
A. I'm not an audiologist.
Q. You're not an audiologist, you're a neurologist, correct?
A. I am.
Q. When was the last time you studied audiology?
A. As part of my neurological training and every day practice of neurology, we examine every

patient for their cranial nerves. One of those cranial nerves is cranial nerve VIII. So although I have not undertaken a degree in audiology and don't perform hearing tests, part of a complete neurological examination is an examination of all of our patient's cranial nerves. Cranial nerve VIII is one of those cranial nerves. And when I examined Mr. Chatwin, he had decreased hearing on the left. We knew he had a skull fracture on the left, and the cranial nerve VIII is a nerve that is susceptible to injury in a skull fracture.

So in answer to your question, I didn't study audiology, but I studied neurology, which involves the cranial nerves.

Q. You have reviewed Mr. Goldman's, or Dr. Goldman's report, correct?

A. I did.

Q. And you actually did a rebuttal to his rebuttal, right?

A. I did.

Q. Okay. In his report do you recall him saying that he would rely upon his otorhinolaryngology -- and I apologize, I just slaughtered that -- otorhinolaryngology colleagues for a definite answer with respect to his tinnitus,

Mr. Chatwin's tinnitus?

A. Okay. We're talking about two different things, then. Tinnitus is the subjective complaint of ringing in the ear. Mr. Chatwin complained of that. He also complained of decreased hearing.

Now, both of those symptoms go along with injury to cranial nerve VIII, and also the cochlea in the ear where hearing is heard, if I may use that word. There's a little -- there's a cochlear organ in your temporal bone in your ear where the cranial nerve VIII interprets the hearing.

So we have a subjective symptom of tinnitus, which is a clinical subjective symptom like I hear a buzz or humming in my ear. That's what tinnitus is. And then we also have him complaining of decreased hearing in his ear.

I examined the patient and he had decreased hearing in his ear and he said, by the way, my ear, I have ringing in my ear, which is the same thing as a buzz or the tinnitus.

So there's kind of two parts to that question, he has decreased hearing and subjective tinnitus. And, now, I'm sorry, I got myself going, you're going to have to ask me that question again.

Q. Okay.

A. How can I answer that question?

Q. Let me move on to a different question. When was the last time you diagnosed someone with tinnitus?

A. I don't diagnose people with tinnitus. They say, I've got a ringing in my ear. I say, you've got tinnitus.

Q. Would you agree with me that there are specialists that can diagnose a person with tinnitus?

A. They can't diagnose it anymore than I can than I just did with you. If they said -- if you came in and said, I've got ringing in my ear, and they said, you don't have ringing in your ear, then you would say, Doctor, either I'm a liar or you aren't telling me the truth.

Q. So when you say that he had tinnitus, you're basing that off of his self-report, correct?

A. That is the only way it gets reported, that is tinnitus. There is no testing that can be done that -- that is -- if somebody comes in -- okay, we're getting off topic, but let's go ahead. If somebody comes in and says, I've got a headache, and the doctor says, no, you don't, you would say this doctor is out of his gore. He's a liar. If you come in and say, I've got ringing in my ear, and the

doctor says, no, you don't, you would say this guy needs his hearing checked, right? Okay. That's what we're talking about.

Q. Sir, you're aware that Mr. Chatwin had gone and seen an otorhinolaryngologist, correct?

A. I am.

Q. And I apologize. How do you say that word?

A. Otorhinolaryngologist.

Q. Otorhinolaryngologist?

A. Uh-huh (affirmative). Audiometrics. Who know audiometrics?

Q. Yeah. I have a brother that teaches up at the University of Colorado and he's an ear, nose, throat specialist, and I never attempt to try to say what he calls himself. I just stick with ear, nose, throat.

A. Yeah. That's reasonable.

Q. So you knew that he had gone and seen that specialist?

A. I did.

Q. And you knew that he had never followed up with that specialist?

A. Okay. If I said that, then I don't remember right now, but, sure. If he just saw him

may be other problems there, but let me just run with that for a minute, please.

When I examined him he had plenty of opportunity to say and exhibit both -- he had plenty of opportunities on his history and plenty of opportunities on his physical examination to have what we sometimes call in the medical professional functional elaboration. You know, sometimes in medicine what we see is almost as -- sometimes in medicine what we don't see is almost as important as what we do see.

By that, I mean this. Is here we have someone who comes in, who, let's be blunt, who has an attorney, who is in some litigation, who you might expect that when you examine his strength, for example, and I'm just making this up a little bit because I'm going to ham this up a little bit, even though it's a deposition. That we examine his strength. Oh, he's weak all over. Or that left arm, oh, my arm, I can't move it, it's weak. Uh-uh. He's strong. Or how are your headaches doing? My headaches aren't doing too bad. In spite of the fact this guy had a skull fracture. Do you know what I mean? And we don't see any -- we don't see any magnification of symptoms.

Are you familiar with that scenario? We don't see any -- what looks like what we used to call sometimes secondary gain when we were doing psychiatry.

Q. Malingering?

A. What's that?

Q. Malingering.

A. Okay.

Q. Is that a term you would use?

A. Well, I hate to use that term. I try to avoid using that term because that provides -- that provided maybe a little less deeper psychological thing than what my old psychiatry professors might used to do. Sometimes they would say that this is a way for the patient without being -- oh, my God, Professor Forage, where are you -- without the patient being aware that they are doing this consciously, that they are just kind of trying to get around it, but he didn't have any of that.

Here's a guy who came in and his exam is amazingly normal. Do you know what I mean? He has no functional elaboration. How are your headaches today? Not too bad. Do you know what I mean? How's your thinking? Pretty good. Do you have any postconcussion symptoms? Not really. Huh? Do you

know what I mean? Like, wait a minute. That means to me that whatever he reports, it is solid. Do you know what I mean? Hey, this is real.

And there's sort of an inverse relationship between the number of symptoms in my experience that a patient will report and the weight that those symptoms need to be given. In some ways the fewer symptoms that a patient reports, the more you need to pay attention to them. The most difficult patients to evaluate, of course, are the ones that have 10,000 symptoms and it's -- and good luck as a doctor because you're flopping in the breeze. You can't figure out what is going on. Do you know what I mean? If somebody comes in with just a few symptoms, boy, you better pay attention to them because something is not good there.

Q. Okay.

A. That's why I consider him reliable. Have I tried to make myself clear?

Q. Let me make sure I understood. I'll just summarize.

A. Yeah.

Q. In essence, the reason you believe he was reliable --

A. Yes.

is intoxicated?

A. I have no special -- I have no special expertise.

Q. So where are you drawing those conditions from? What --

A. Research off the internet.

Q. So when you were asked that question by Ms. Marcy, the effect of alcohol --

A. Yeah.

Q. -- and balance, posture and coordination, what you did is just got online --

A. I got online.

Q. What did you look at?

A. I looked at probably UpToDate, which is an online, oh, what do you call it, medical thing for doctors. You know what I mean? And then just -- I don't remember what I Googled, just, you know, alcohol levels, cognition, you know, correlation between alcohol levels and functioning, or I don't remember exactly what, or exactly where, but that's what I did.

Q. Okay. With respect to this UpToDate, is that a peer reviewed --

A. Yes.

Q. -- source?

A. Yes.

Q. And do you recall what information you were actually able to get off of UpToDate?

A. Of that, no, but it's an online thing. It's a subscription thing and it's peer-reviewed and -- but I -- I don't know if I actually used that for UpToDate or if I just went on like Medscape or PubMed or what or those other -- Medscape, PubMed, UpToDate, and that. I just Googled around and looked for alcohol levels correlating with mental status.

Q. Would you agree with me to be able to render this opinion that, in essence, what you did is a Google search?

A. That's basically true. That is what I did.

Q. You did a Google search?

A. With also the online things that I have available to me.

Q. When you say the online things that you have --

A. Like UpToDate.

Q. Are there any other things besides UpToDate that you may have looked at?

A. Yeah. I'm sorry. I don't remember. It could have been PubMed, UpToDate, Medscape. I just

in his ear."

Question: "So could you put that in layperson's terms?"

THE WITNESS: The two kind of go together, because oftentimes when the nerve is injured, then people have, in addition to having a hearing loss, they also have ringing in their ears.

Q. (By Ms. Marcy) Do you ever see patients, let's say, younger than 40 that have the arthritis in their ear that causes tinnitus?

A. Yes. It can happen at any age. Oftentimes, if somebody has the otosclerosis, which is the arthritis there, they may also have other -- they may have a rheumatological condition that can cause it, like rheumatoid arthritis, things like that, that can produce that kind of thing. But in general, it's a condition that happens to older patients.

Q. Did Josh Chatwin have any signs of this type of arthritis?

A. No. Because, really, I'm thinking more that his tinnitus and hearing loss were due to injury of the nerve itself from the skull fracture.

Q. I was a little unclear on the boards certified stuff. You said you were board certified

in psychiatry, but you don't practice psychiatry.

A. Now. The board certification, the name of the board is The American Board of Psychiatry and Neurology. Now, I did a neurology residency. As part of that residency, we rotate through psychiatry to get training in psychiatry. But the emphasis of my boards is neurology. But I did actually take a part of my both written examination and my oral examination in neurology included a psychiatry component.

Q. Okay. When you were a resident, did you prescribe, what would you call it?

A. Psychiatric medication.

Q. Psychiatric medication?

A. Yes. When I was rotating through psychiatry, I prescribed actually medication for things like schizophrenia, and, you know, excessive compulsive disorder, anxiety, and all that kind of stuff. But I don't do that anymore. That was when I was a resident rotating through that service.

Q. How did you know what medications to give to which person with the mental illness?

A. Well, because I was in training then and we had attendings that were supervising us.

Q. I watch Grey's Anatomy.

A. Okay. That's how we knew, we had attendings that said do this. We had real psychiatrists that would tell us what to do.

Q. Okay. And so when you talked about -- you talked about you weren't sure anymore that you could give an opinion about the force that would cause a shoulder injury. Why did you feel at the time that you could give that opinion?

A. Because in answer to that question I looked back and thought, gosh, Mr. Chatwin is a pretty muscular guy. In answer to Mr. Hamilton's question about do people generally just collapse to the ground if they've been drinking too much, and, again, this is not my medical experience, but personal experience, but, yes, they can. It's just a collapse to the ground. You know what I mean? They're just flopping all over and fall to the ground. It was more of a lay opinion than, really, a medical opinion or an expert opinion. That is why.

Q. Do you have a sense, as a doctor, do you have a sense, even in a general way, about what kind of force would cause damage to a shoulder?

A. Okay.

Q. Making contact with cement.

A. Okay. In part -- I don't really. In

part, it depends on did that person -- in what way did the person land on their shoulder, was it a curb, was it flat, was their arm extended, was their arm tucked to their side. I don't know if I would want to go out on a limb and -- you know what I mean? What was the position of the shoulder, was it internally rotated, externally rotated, was there a sharp curb there, and this kind of stuff.

Q. But I notice that you're describing scenarios about -- you're describing what you need to consider in addressing the force, so how do you know those -- how do you know how to do that?

A. For me, I don't know how. I just have to -- maybe if -- you would have to ask the observers on the scene kind of what happened, I guess.

Q. No. I mean how did you know how to talk about different scenarios?

A. Me?

Q. Right. Like whether the arm was extended or --

A. Just from my personal experience as a doctor.

Q. Okay. Let's talk about this alcoholism, the paragraph that -- paragraph 5 that talks about the .319, the one you said you looked it up online.

A. Yeah.

Q. Do you get any training on the effects of alcohol on the body?

A. Okay. Okay. Oh, my God, going back a long time ago I did training as an internal medicine resident in St. Louis, which included rotations at St. Louis City Hospital. We saw a lot of drunks there. The hospital has been torn down since. And so in those days I knew, you know, a little bit more about alcohol and stuff and levels and how to detox these people, whatever, but I haven't done that for a long time.

Q. I'm not talking about levels. I'm talking about just the effects of alcohol on a body.

A. Oh, okay. Look, I mean, I just know from my neurology training in general where I tend to get involved with alcohol tends to be about withdrawal seizures in people that have drank too much. People that are intoxicated, and like this gentleman here, one way or the other end up with some kind of a head injury. Long-term effects of alcohol on the nervous system, both centrally and peripherally, including things like peripheral neuropathy, cerebella degeneration, cirrhosis and the effects of cirrhotic livers on the brain and that kind of stuff. But,